THE GORDON WILSON LECTURE "THE DOCTOR IN OUR OWN TIME": FILDES' FAMOUS PAINTING AND PERCEPTIONS OF PHYSICIAN ATTENTIVENESS

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It is an honor to present the Gordon Wilson lecture at the 120th meeting of the American Clinical and Climatological Association. I have chosen a topic that concerns us all, and that is the *perceptions* patients have of physicians.

A consistent theme I hear from friends and family and from people who learn that I am involved in teaching ethics and humanities to medical students, is that in their perception, medicine as a system (and often those of us who work in it) seems inattentive; medical care feels impersonal and too subservient to technology. The paradox, of course, is that these sentiments come forth at a time when striking advances in scientific research promise unparalleled breakthroughs in our ability to prevent and treat many conditions.

THE DOCTOR BY FILDES

It is fitting to begin this discussion by examining Sir Luke Fildes' famous painting, *The Doctor,* (Figure 1) because this painting has influenced public perceptions of medicine and it has even been exploited by the medical world to misinform the public. Few paintings in medicine can be called iconic, but *The Doctor* is certainly one of them; it is among the best-known medical paintings in the Western world, and it has been used frequently through the decades to reflect a point of view about medicine and medical care.

Y. Michael Barilan, in a paper in the *Journal of Medical Humanities* earlier this year, discussed this painting at length in an article entitled, The Doctor by Luke Fildes: An Icon in Context' (1) and I have drawn heavily on this source in my remarks.

Just a few years after the painting's debut, over a hundred years ago, Professor Mitchell Banks of the Royal Infirmary in Liverpool was so struck by the painting and its public reception that he made the

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FIG. 1. Sir Luke Fildes, "The Doctor," oil on canvas, 1891. With permission from The Tate Britain, London.

notable comment that "a library of books written in our honor would not do what this picture has done and will do for the medical profession. . ." (2) A century later, his statement still holds true.

Luke Fildes was born in Liverpool on October 3, 1843, the son of James Fildes of Chester. We know that his grandmother, with whom the young artist lived much of his childhood, was a political activist and heightened her grandson's awareness of the struggle against technology and industrialism and the push for better working conditions.

Fildes was sent to London to study at the Royal Academy Schools, where he did well. He became an illustrator of books and magazines and, in 1869, received a commission to draw something of "importance" for which he could choose his own subject. What appealed to him was a scene he had witnessed on the streets of London. *Application for Admission to a Casual Ward,* or later, *Homeless and Hungry* (Figure 2) was the result. His models were actual people from the streets, which contributed to the realism.

Fildes later transformed this illustration which appeared in a magazine into an oil painting. It drew many admirers at the Royal Academy, including Charles Dickens, who invited him to illustrate his new novel, *The Mystery of Edwin Drood,* a story that appeared in six installments but was unfinished at the time of Dickens' death. *Home-*

FIG. 2. Sir Luke Fildes, "Homeless and Hungry," oil on canvas, 1891. With permission from The Tate Britain, London.

less and Hungry had many qualities that he maintained in his later work when he returned to depicting social realism. This painting demonstrated Fildes' ability to draw his viewers into the scene and its action, and the misery and emotion of his subjects' situation. Its realism, even now, seems harsh and compelling and deeply pessimistic.

In 1880, Henry Tate, an enthusiastic patron of the arts, who had made his fortune in the Caribbean sugar business, commissioned Fildes to create a painting that reflected social realism. Tate would exhibit the new commission on the occasion of offering his art collection known today as Tate Britain to the English nation in the spring of 1891.

Fildes had complete freedom in choosing his subject matter, and he drew on a personal experience: the death of his eldest son, Phillip, in 1877. In spite of the great loss, Fildes had deep gratitude to and admiration for the doctor who had tended his dying child. He decided to take advantage of his most important public commission in order "to put on record the status of the doctor in our time." (3). In his studio, he created a model of the interior of a Devon fisherman's cottage and composed a scene that is memorable now as it was more than 100 years ago. This painting has hung continuously at the Tate since it opened, one of only 57 to achieve this status. (1)

In *The Doctor,* the gravely ill child is in the center and draws the eye

immediately. The soft light shines on the child and the doctor, the two central figures. The doctor, to the left, the table with medicine, and the parents in the shadow to the rear create an atmosphere of vigil and sadness. The father is looking intently at the physician, who is gazing at the child. The mother's anguish is evident from her bent head.

In his paper, Michael Barilan notes that although the hands are seen as "instruments of healing," the doctor does not touch the child, and he reminds us about a familiar motif in Western art - hands that relate but do not touch - of which a very well-known example is Michelangelo's *The Creation of Man* in the Sistine Chapel. (1)

There are many gentle touches - the father with his hand on his wife's shoulder, helping her despair, and the angle for the doctor's head indicating concern, inquiry, watchfulness. The bed is simple, cobbled together for the ill child with chairs. The common touches - the little lamp with its soft light, the medicine, the water jug and basin, even the little table, create a scene with which many can identify.

Barilan points out that the doctor has already made his diagnosis and prescribed therapy and is now watching intently for signs of recovery. The painting suggests this is a real doctor at work, his insights gained from many years of bedside experience. In this era of Victorian England, the doctor is not a tradesman but a gentleman master of an art. There are no new-fangled tools of the trade, such as a stethoscope, thermometer, ophthalmoscope in this painting. Nor does the doctor look at any one part of the body. He considers the whole being.

An interesting point about the painting is that while the doctor is a consultant-type dressed fashionably, he is acting as an older-style family doctor in a setting that belongs to a rural family. At the time there was tension between these two very distinct types of physician, but the painting indicates a unified approach to medicine. The fisherman and his family would have called a general practitioner, but not one who would have been able to afford the quality attire of the physician in this painting. The elite doctors combined charitable hospital work with their lucrative private practices. The GPs by contrast, had to find employment by clubs or societies in each village that took subscription from their members and elected their doctors by annual ballot.

This was as Barilan points out, a time of huge medical advances: revolution in surgery because of the development of anesthesia and antiseptics. A rural doctor-patient scene was an unusual choice for a painting.

ART AS POLITICAL ICON

Over the years, *The Doctor* has found its way onto posters, calendars, and has appeared on postage stamps both in Britain and the United States. Most unusual for a painting, it was also used at one time for propaganda. When President Truman proposed a form of nationalized medical care, the American Medical Association went on a war footing, determined to nip any such legislation in the bud. The AMA's brilliant public relations campaign in 1949 revolved around *The Doctor,* which was reproduced on countless brochures and posters along with the slogan, "Keep Politics Out of this Picture." The implication, which preyed on the fears of parents, was that Truman's plan would mean that a poor sick child like the one in the famous painting could not count on getting this kind of care.

Many Americans still recall seeing the image in their doctor's office. TIME magazine in December 1949 reported that "more than 55 million pieces of campaign literature were distributed . . .and over 65,000 posters of *The Doctor* went up in medical offices and elsewhere." (4) The campaign was extremely successful and the AMA had achieved its victory. Indeed one could argue that a lingering public skepticism for any such proposal (despite rising health care costs and inability of employers to provide health coverage) dates back to that campaign.

In Britain, by contrast, nationalized medicine took hold, and in 1998, *The Lancet,* which had fought for such a nationalized system and against the "club wars' and private contract practices, celebrated the 50th anniversary of the National Health Service by reproducing the image of *The Doctor* in a celebratory issue. At least on that side of the ocean, the image was an icon for affordable, medical care for all.

Stepping away from the political and looking at the painting on a more individual and personal level, a different kind of interpretation emerges. For many, such as family physician and ethicist Howard Brody, the painting depicts the ideal family physician, and Brody argues that for a family physician, "character and virtue are as important as knowledge and skills." (5)

In my personal view, the painting is not about the doctor. I would argue that the painting resonates because all viewers (physicians are no exception) identify, if only subconsciously, with the central figure in the painting, namely that of the child. The painting represents our desire to be cared for with the kind of single-minded attentiveness of the physician seated to the left of the child. Illness renders us helpless, it infantilizes us. When our minds are preoccupied by fear, by discomfort, by fever, we are very clear about what we need. The painting recalls for me a verse in the Bible, "I was ill and you cared for me" (6),

and the later verse in the same chapter, "Whatsoever you do to the least of these, my brothers and sisters, you do unto me." (7)

The physician is our idealized desire: he has offered himself, sacrificed his own comfort, put aside matters of class and caste, or compensation to offer this one thing that only he has the power to offer: his presence through the night, and his unswerving dedication to the child.

RECASTING THE IMAGE OF THE DOCTOR

In preparing for this lectureship, I read several previous *Transactions of the American Clinical and Climatological Association*. I found myself reading with great fascination the tributes to members who had passed away, learning the story of a professional career, but also trying to imagine the personal from the few brushstrokes offered. In a memorial for Orville "Pete" Horwitz, M.D. I learned that his remarkable career in medicine was capped by a novel, *From Mount Olympus to the Moon* (1999). The memorialist, Dr. Frank Gardner, writes of Dr. Horwitz that, like many in his profession, Horwitz "worried that the enthusiasm with instrumentation rather than with the patient was a loss of compassionate professional care." (8) I love that phrase "enthusiasm for instrumentation." Taking some liberties with the Fildes painting to reflect current medical practice, we could well substitute a large computer monitor for the child in the center of the painting.

I have felt for some years now as I walk through modern hospitals, that the patient in the bed has become an icon for the real patient who is in the computer. (9,10). I recall a photograph of the great infectious diseases physician Maxwell Finland (1902–1987) on rounds at Boston City Hospital (Though I trained at Boston City Hospital in the mid 80s, and saw and spoke to Finland at conferences and walking the halls, he was retired by then). In that photograph Finland is surrounded by six students and residents who are observing intently. Finland is clearly instructing, and the patient is listening. That photograph is a heartwarming sight, but unfortunately these days what it depicts is rare. Too often "chart rounds' or "card-flip rounds' happen away from the patient. Therefore, no matter what else they achieve, they don't bring comfort to the patient because the patient is unaware that such a discussion on his or her behalf is even taking place.

The importance of an attentive, thoughtful presence at the bedside by the physician cannot be overestimated - one might "cure' without seeing a patient, but to "heal' a patient requires presence. These

concepts of healing versus curing are from the work of Eric Cassell (11) and others; in my own case, having trained in infectious diseases just before HIV arrived, I see myself as having been caught up in the conceit of medicine, the sense that cure was all that mattered. But in dealing with an incurable disease that resulted in death (in those early days), in not having a cure to dispense, I think many of us learned or stumbled onto the realization that we could heal, by simply engaging with the patients, particularly by seeing them in their homes.

The effect of such a visit was powerful. It was probably what the doctor depicted in Fildes' painting had to offer. Fildes' son died after the long vigil by his physician, Dr. Murray, and despite that, Fildes' gratitude to the physician was enormous. Dr. Murray healed by his presence, even if his patient died.

In an interview, Eric Cassell said, (11) "As far as I can see, you can heal somebody. You can be complete about it. I'm not convinced that you make a bit of difference in the bodily disease." Thus, healing is independent of illness, impairment, cure of disease, or death. In *The House of God,* Roy Basch echoes this opinion: "I didn't give a damn about their diseases or 'cures'; what they wanted was what anyone wanted: the hand in their hand, the sense that their doctor could care." (12)

TECHNOLOGY IN PERSPECTIVE

The "hand in their hand" captures well what it is a patient wants. For a patient, being sent for this test or that test, necessary as that might be, does not convey to the patient "the sense that their doctor could care."

I am no Luddite, and yet I think it is important to look critically at technology, particularly when it contributes to the patient's sense that the system is inattentive. Jacques Ellul, a French philosopher, theologian and sociologist argues in a remarkable book, *The Technological Bluff,* that we have no philosophy of technology because "philosophy implies limits and definitions and defined areas that techniques will not allow." (13) So instead, we are "shut up, blocked and chained by the inevitability of the technical system." He might not have been talking about medicine directly, but it does seem to apply.

Neil Postman, in a book entitled *The Surrender of Culture to Technology,* goes further and sees a clear progression from simple tools to technocracy to technopoly, which "eliminates alternatives to itself." (14)

Both of these authors are quoted in the work of David Orr from

which are derived my comments below. In trying to articulate the tensions between a style of practice that is heavily based on being present with the patient versus a style of practice that seems to revolve around the computer and tests and information, the ecologist David Orr's work is intriguing. His concept of slow and "fast' knowledge seems to have great applicability to medicine.

In his book, *The Nature of Design,* (15) Orr says, "The modern dilemma is that we find ourselves trapped between the growing cleverness of our science and technology and our seeming incapacity to act wisely." He differentiates between the two types of knowledge, saying that, "The aim of slow knowledge is resilience, harmony, and the preservation of long-standing patterns that give our lives aesthetic, spiritual and social meaning."

Fast knowledge, by contrast, operates with the following (false) presumptions: if it can be measured, it is important, and if it can't, it isn't; more information is better and there is little distinction between information and knowledge; fast knowledge presumes that if we forget old knowledge, it doesn't matter since the new knowledge is better; it presumes that mistakes from new knowledge will be solved by more knowledge and, finally, that the acquisition of knowledge has no duty of responsible use.

Fast knowledge in the medical context then represents technology carried to excess, forgetting the patient's fundamental needs. Slow knowledge, on the other hand, in the way Orr describes it, sounds very much like clinical wisdom, and is the kind of thing we want to develop in our trainees. Orr lists the following as inherent to slow knowledge:

- Wisdom, not cleverness is the goal of learning
- The velocity of knowledge is inversely proportional to the acquisition of wisdom
- Careless application of knowledge can destroy the conditions that permit knowledge to flourish
- Rising volume of knowledge cannot compensate for increasing errors caused by malfeasance and stupidity generated in part by inappropriate knowledge
- The good character of knowledge creators is relevant to the truth they intend to advance

These are not issues I hear being discussed very much in clinical medicine. It is as if we are wedded to a course, unable to function except in a style of practice that is heavily dependent on technology and that is so specialized that care is necessarily fragmented. The electronic chart is tidy (and voluminous) and we have ordered HbA1c

as often as we should in our diabetics, and prescribed flu vaccine to all our patients who should be on it, but are these the markers that really count? Can they convey the kind of attentiveness that patients seem to perceive is lacking?

Meanwhile, a gulf has developed between the patient and the physician; the physician is in possession of reams of data about the patient, and perhaps feels that he or she "knows' the patient extremely well in this digital fashion; however, the patient rarely appreciates this kind of knowledge.

In my view, the best way, and perhaps the only way, to convey our attentiveness, our caring is by our presence. The careful, time-honored means of the interview and the laying of hands during a thorough physical exam go a long way toward establishing a patient-physician relationship and gaining the patient's trust. If we want to teach "slow knowledge,' it will be necessary that bedside rounds be at the bedside. We should bring patients to grand rounds and invite them into a dialogue about their situations. We should train our students as if they will go to work in a resource-poor area or refugee camps - and many will - and make sure they have the requisite bedside skills so that with a patient presenting with a neurological deficit, they are not completely helpless without an MRI or CT scan. We need to focus on our junior faculty who often want, but don't necessarily have these bedside skills, and we must create opportunities for seasoned and retired physicians - repositories of slow knowledge - to share their experiences. We can measure less and reflect more.

I read in William Butler Yeats's poem, *The Choice,* (16) the kind of duality that medicine is faced with. Yeats says,

The intellect of man is forced to choose Perfection of the life, or of the work, And if it takes the second, must refuse A heavenly mansion raging in the dark.

Technology goes well with perfection of the work. But if our intent is the whole patient, if we still believe the practice of medicine has some connection with the sentiments Fildes' painting elicits in us as viewers, then perhaps it is perfection of the life that we are after, or better still, perfection of the life and of the work, bringing both healing and curing to the patient.

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